C.L. "BUTCH" OTTER – Governor RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T - Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720-0036 Boise, Idaho 83720-0036 PHONE: (208) 334-6626 FAX: (208) 364-1888 E-mail: fsb@dhw.idaho.gov

September 15, 2009

Thair Pond, Administrator Tomorrow's Hope—Eagle 1655 Fairview Avenue Suite 100 Boise, Idaho 83702

RE: Tomorrow's Hope—Eagle, Provider # 13G047

Dear Mr. Pond:

This is to advise you of the findings of the Medicaid/Licensure Fire Life Safety Survey, which was concluded at Tomorrow's Hope—Eagle, on September 10, 2009.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. <u>It is important</u> that your Plan of Correction address each deficiency in the following manner:

- 1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;
- 2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- 3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
- 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

Thair Pond, Administrator September 15, 2009 Page 2 of 2

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **September 28, 2009**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208) 334-6626.

Sincerely,

TAYLOR BARKLEY

Health Facility Surveyor

Mul 2 602

Facility Fire Safety and Construction Program

TB/li

Enclosures

C.L., "BUTCH" OTTER - Governor RICHARD M. ARMSTRONG - Director DEBBY RANSOM, R.N., R.H.I.T – Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720 Boise, Idaho 83720-0036 PHONE: (208) 334-6526 FAX: (208) 364-1888 E-mail: Isb@dhw.idaho.goy

October 6, 2009

Thair Pond, Administrator Tomorrow's Hope 1655 Fairview Avenue Suite 100 Boise, Idaho 83702

RE: Request for Waiver of *IDAPA* 16.03.11.110.02.(e) for Armga, Meridian, Sapphire, Eagle, and Navarro Homes

Dear Mr. Pond:

This office has received your request dated for a waiver of the non-combustible wastebasket requirement.

Your request for waiver is approved in accordance with *IDAPA* 16.03.11.700 for a permanent variance with the following conditions:

- 1. A designated smoking areas outside each facility be equipped with appropriate ashtrays.
- 2. A single non-combustible trash receptacle be provided nearby for the disposal and holding of smoking materials.
- 3. Smoking materials are to be transferred and held in the non combustible container for a period of not less than 24 hours before being placed with outgoing trash.

With the above consideration, all other trash and waste containers may be of any type construction suitable to produce a more home like environment. Please keep in mind the requirements of *IDAPA* 16.03.11.100.3.a when deciding on the design of the trash containers.

If you have any questions, please contact Mark P. Grimes, Supervisor, Facility Fire Safety and Construction at (208) 334-6626.

Sincerely,

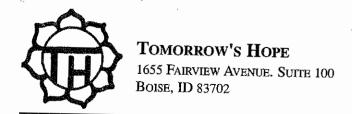
MARK P. GRIMES

Supervisor

Facility Fire Safety and Construction

MPG/li

C: Nicole Wisenor, Co-supervisor, Non Long Term Care Program



PHONE: (208) 319-0760 FAX: (208) 319-0765

Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction Program Bureau of Facility Standards PO Box 83720 Boise, Idaho 83720-0036

RECEIVED

SEP 28 2009

FACILITY STANDARDS

24 September 2009

RE: Request for Waiver

Dear Mr. Barkley,

During your recent survey of our 5 Intermediate Care Facilities, you found a deficiency in State Tag MM324. (IDAPA 16.03.11.110.02(e)). Our current waste receptacles are not made of non combustible material.

I am requesting a waiver for this Tag. Our facilities are non smoking and there is little if any risk of burning material being placed into the waste cans.

In addition, the current waste receptacles are much more home like and present a more normal environment for our residents.

Therefore, I am requesting waiver of this tag for our Armga home, Medicaid #002535000, our Meridian home, Medicaid #002534800, our Sapphire home, Medicaid #002534900, our Eagle home, Medicaid #002535100, and our Navarro home, Medicaid #804053500.

Thank you for your time and effort in this manner. If you have any questions, please contact me at the above numbers.

Sincerely.

Thair Pond Administrator

CC file, homes

Printed: 09/11/2009 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG 02	(X3) DATE SURVEY COMPLETED	
		13G047	,	B. WING _		09/10	/2009
TOMORROW'S HOPE - EAGLE 1057 Rt			RESS, CITY, USH ROA , ID 8361	•—			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	TS		K 000			
	residential building in living spaces and heads. It has a co- detection system. licensed for seven	gle story Type V (000 built in 1992. It is sp d closets with quick re mplete fire alarm/smo Currently the building (7) ICF/MR beds. The accordance with 42 C	orinklered esponse oke g is ne survey			CEIVE	E D
The following deficiencies were cited during the fire/life safety survey on September 10, 2009.  The annual fire/life safety survey was conducted by:				SEP 2 8 2019			
					LITY STAND		
	Mark Grimes Supervisor						
K0046 483.470(j)(1)(i) LIFE SAFETY CODE STANDARD			K0046	K0046			
	Utilities comply with 33.2.5.1	Section 9.1. 32.2.	.5.1,		The mulitiple electical adapter was Para Q	s removed. responsible by 09/30	0/09
LARODATO	Based on observat facility failed to ens Section 9.1.	ot met as evidenced ion it was determined ure that utilities comp	I that the blied with	NATI IDE	Staff to be trained to ensure requiare met on a continuum. Para Q t checks for compliance during weel checks.  Para Q respons	to enclude kly house sible by 10/3	30/09 (X6) DATE
	Jan CO	1 / /	Pond, Admini		09/24/09		(m) Maile ,

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Printed: 09/11/2009 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION
A. BUILDING 02

(X3) DATE SURVEY COMPLETED

13G047

B. WING\_

09/10/2009

NAME OF PROVIDER OR SUPPLIER

TOMORROW'S HOPE - EAGLE

STREET ADDRESS, CITY, STATE, ZIP CODE

1057 RUSH ROAD

TOMORROW S HOPE - EAGLE			E, ID 83610				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEEDED B REGULATORY OR LSC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
K0046	Continued From page 1		K0046				
	Findings include:						
	During the facility tour on September 10 1:29 PM, observation of the Office revea multiple electrical adapter in use. The fir were observed by facility staff and surve	aled a ndings					
K0051	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD		K0051	K0051			
	A manual fire alarm system is provided accordance with Section 9.6, 33.2.3.4.1.			Fire Alarm box locked to meet requirements  Maintenance responsible by 09	/30/09		
	Exception No 1: Where there are interest smoke detectors meeting the requireme 33.2.3.4.3 and there is not less than one fire alarm box per floor arranged to cont sound the smoke detector alarms.	ents of manual		Fire Alarm box to remain locked and checked during monthly maintenance checks and reviewed during Monthly Quality Assurance reviews  Para Q and Q responsible by 10/	/30/09		
The act of the state of the sta	Exception No. 2: Other manually activate continuously sounding alarms acceptable authority having jurisdiction.	ed le to the	•				
				••			
	This Standard is not met as evidenced Based on observation, it was determined facility did not have the fire alarm system accordance with NFPA 72.	d that the	ļ				
	Findings include:			•			
	During the tour of the facility on September 2009, at 1:03 PM, observation of the Fire Control Panel revealed that the door to tour controls was unlocked. Findings were with the controls was unlocked.	e Alarm he panel					

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CENTERO TOR MEDIOARE & MEDIOARE SERVICES							
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02	(X3) DATE SURVEY COMPLETED			
		13G047	B. WING	09/10/2009			
ı	NAME OF PROVIDER OR SUPPLIER	STREET ADDR	ESS, CITY, STATE, ZIP CODE				

**TOMORROW'S HOPE - EAGLE** 

1057 RUSH ROAD

		EAGLE, ID 8361	6	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEEDED B' REGULATORY OR LSC IDENTIFYING INFORM	Y FULL PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0051	Continued From page 2 and noted by facility staff and surveyors.  NFPA 72 National Fire Alarm Code 1999 1-5.4.8 Alarm Signal Deactivation.  A means for turning off activated alarm notification appliances shall be permitted where it is key-operated, located within a cabinet, or arranged to provide equivale protection against unauthorized use. Sushall be permitted only if a visible zone a indication or the equivalent has been prospecified in 1-5.7.1, and subsequent activitiating devices on other initiating device or subsequent actuation of addressable devices on signaling line circuits cause to notification appliances to reactivate. A mis left in the "off" position when there is alarm shall operate an audible trouble sist the means is restored to normal. If autor turning off the alarm notification appliance permitted by the authority having jurisdical alarm shall not be turned off in less than minutes.  Exception No. 1: If otherwise permitted to authority having jurisdiction, the 5-minute requirement shall not apply.  Exception No. 2: If permitted by the authority jurisdiction, subsequent actuation another addressable initiating device of type in the same room or space shall no required to cause the notification appliar reactivate.	d only a locked nt ch means alarm ovided as ruation of the circuits initiating the neans that is no ignal until matically ces is otion, the to to to to the to to the to to the the to the		
	1-5.4.9 Supervisory Signal Silencing. A means for silencing a supervisory sign notification appliance(s) shall be permitte it is key-operated, located within a locker enclosure, or arranged to provide equivalence protection against unauthorized use. Sugmeans shall be permitted only if it transfer	ed only if d alent ch a		

Printed: 09/11/2009 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 02

(X3) DATE SURVEY COMPLETED

13G047

B. WING \_\_\_\_\_\_

09/10/2009

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TOMORROW'S HOPE - EAGLE

1057 RUSH ROAD EAGLE, ID 83616

	EAGL	E, ID 83616	6	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0051	Continued From page 3 supervisory indication to a lamp or other visible indicator and subsequent supervisory signals in other zones cause the supervisory notification appliance(s) to re-sound. A means that is left in the "silence" position where there is no supervisory off-normal signal shall operate a visible signal silence indicator and cause the trouble signal to sound until the silencing means is restored to normal position.	K0051	K0147 Emergency plans to be developed and in place and procedures trained to staff Program Director and Administrator responsible by 10/30	0/09
K0147	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD  The administration of every resident board and care facility has in effect and available to all supervisory personnel written copies of a plan for protecting of all persons in the event of fire, for keeping persons in place, for evacuating persons to areas of refuge, and for evacuating persons from the building when necessary. The plan includes special staff response, including fire protection procedures needed to ensure the safety of any resident, and is amended or revised whenever any resident with unusual needs is admitted to the home. All employees are periodically instructed and kept informed with respect to their duties and responsibilities under the plan. Such instruction is reviewed by the staff not less than every 2 months. A copy of the plan is readily available at all times within the facility. 32.7.1, 33.7.1	K0147	Plans and procedures are to be in place and procedurs trained. Evacuation drills are to be ran and documented monthly and at least ever two months per shift. Documentation is to be reviewed during monthly Quality Assurance Review  Para Q and Q responsible by 10	
	This Standard is not met as evidenced by:			

Printed: 09/11/2009 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIED IDENTIFICATION NUM		A. BUILDIN				
13G04 <sup>-</sup>		B. WING		09/10/2009				
	ROVIDER OR SUPPLIER ROW'S HOPE - EAC	GLE	1057 R	DRESS, CITY, STATE, ZIP CODE RUSH ROAD E, ID 83616				
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	'ION SHOULD BE 'HE APPROPRIATE	(X5) COMPLETION OATE	
K0147	Based on interview determined that the there was a plan for in the facility.  The findings include Staff interview and 10, 2009, at 1:16 P not find a plan for the facility and staff the plan consisted of the facility and the facility and staff the plan consisted of the facility and the facility an	and record review, it e facility had not ensu r the protection of all	persons  otember ff could ersons in now what	K0147				

Bureau of Facility Standards STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09/10/2009 13G047 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1057 RUSH ROAD TOMORROW'S HOPE - EAGLE **EAGLE, ID 83616** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) M 000 M 000 16.03.11 Inital Comments The facility is a single story Type V (000) residential building built in 1992. It is sprinklered in living spaces and closets with quick response heads. It has a complete fire alarm/smoke detection system. Currently the building is licensed for seven (7) ICF/MR beds. The survey was conducted in accordance with applicable SEP 28 2009
FACILITY STANDARDS fire/life safety requirements set forth in IDAPA 16.03.11 Rules Governing Intermediate Care Facilities for the Mentally Retarded (ICF/MR). The following deficiencies were cited during the fire/life safety survey on September 10, 2009. The annual fire/life safety survey was conducted by: Taylor Barkley - Lead Health Facility Surveyor Fire/Life Safety and Construction Program Mark Grimes Supervisor Fire/Life Safety and Construction Program MM324 MM324 16.03.11.110.02(e) Wastebaskets MM324 Facilty to rquest waiver to meet this requirement. Facility is non smoking and the current All wastebaskets must be of noncombustible or waste recepticles provide a more normal home other approved materials. like environment. See attached waiver This Rule is not met as evidenced by: request. Based on observation it was determined that wastebaskets that were not made of Adminitrator responsible by 09/30/09 noncombustible material. Findings include: During the facility tour on September 10, 2009 at 1:30 PM, observation of the Office revealed a wastebasket that was not made of

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Thair Pond, Administrator

TITLE

(X6) DATE

09/24/09

PRINTED: 09/11/2009 FORM APPROVED Bureau of Facility Standards (X3) DATE SURVEY COMPLETED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A, BUILDING 02 B. WING. 09/10/2009 13G047 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1057 RUSH ROAD **TOMORROW'S HOPE - EAGLE EAGLE, ID 83616** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) MM324 Continued From Page 1 MM324 noncombustible material. Findings were witnessed and noted by facility staff and surveyors.